AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

I hereby authorize _____ (physician or facility) to release my medical records to:

AD ASTRA EYE, LLC
4955 Research Park Way,
Lawrence, KS 66047
785-424-8805 (phone) 913-229-7030 (fax)

Covering period of treatment FROM: _____ TO: _____

And/or Last Clinic Notes, Visual Field, and OCT